NHS
Quality Improvement Scotland

NHS Argyll & Clyde

Local Report ~ *January 2007*

Maternity Services

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Maternity Services

The maternity services standards apply to specific areas of the service. The clinical standards cover the period of time between confirmation of pregnancy, through until the baby is 6–8 weeks old. The project group developed five standards, covering: core principles; pre-conception and very early pregnancy; pregnancy; childbirth; and postnatal and parenthood. This report presents the findings from the peer review of performance against the standards.

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Information contained in this report has been supplied by NHS boards, or taken from current NHS board sources, unless otherwise stated, and is believed to be reliable on publication.

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1 Setting the scene

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland. We do this by setting standards and monitoring performance, and by providing NHSScotland with advice, guidance and support on effective clinical practice and service improvements.

About this report

The 'Clinical standards for maternity services' were published in March 2005. These standards are being used to assess the quality of services provided by NHSScotland nationwide.

This report presents the findings from the peer review of **NHS Argyll & Clyde**.[1] This review visit took place on **20 June 2006**, and details of the visit, including membership of the review team, can be found in Appendix 2.

[1] At the time of the review visit there were 14 territorial NHS boards and eight special health boards. Prior to 31 March 2006 and the dissolution of NHS Argyll & Clyde there were 15 territorial boards. As the review programme cut across this date 15 reports have been presented in order to accurately reflect service provision at the time.

1.1 How the standards were developed

In June 2002, a maternity services project group was established and chaired by Dr Jane Magill, Director, Robert Clark Centre for Technological Education, University of Glasgow. Membership of the maternity services project group includes both healthcare professionals and members of the public (see Appendix 3).

Members of the maternity services project group are involved in the quality assurance process of:

- developing standards
- reviewing performance against the standards throughout Scotland, using self-assessment and external peer review, and
- reporting the findings from the review.

When developing the maternity services standards, a Scotland-wide consultation process was undertaken. The views of health service staff, women (pre and postnatally), and the public were sought, and all the relevant evidence available at the time was taken into account. Draft standards were also piloted in NHS Highland, NHS Lanarkshire and NHS Lothian in June 2004.

1.2 How the review process works

The review process has two key parts: local self-assessment followed by external peer review. First, each NHS board assesses its own performance against the standards. An external peer review team then further assesses performance, both by considering the self-assessment data and visiting the NHS board to validate this information and discuss related issues. The review process is described in more detail below (see also the flow chart on page 9).

Self-assessment by NHS boards

On receiving the standards, each NHS board assesses its own performance using a framework produced by NHS QIS. This framework includes guidance about the type of evidence (eg guidelines and audit reports) required to allow a proper assessment of performance against the standards to be made.

The NHS board submits the data it has collected for this self-assessment exercise to NHS QIS before the on-site visit, and it is this information that constitutes the main source of written evidence considered by the external peer review team.

External peer review

An external peer review team then visits and speaks with local stakeholders (eg staff, patients and carers) about the services provided. Review teams are multidisciplinary, and include both healthcare professionals and members of the public. All reviewers are trained. Each review team is led by an experienced reviewer, who is responsible for guiding the team in its work and ensuring that team members are in agreement about the assessment reached.

The composition of each team varies, and members have no connection with the NHS board they are reviewing. Both of these factors facilitate the sharing of good practice across NHSScotland, and ensure that each review team assesses performance against the standards rather than make comparisons between one NHS board and another.

At the start of the on-site visit, the review team meets key personnel responsible for the service under review. Reviewers then speak with local stakeholders about the services provided. After these meetings, the team assesses performance against the standards, based on the information gathered during both the self-assessment exercise and the on-site visit. The visit concludes with the team providing feedback on its findings to the NHS board. This includes specific examples of local initiatives drawn to the attention of the review team (recognising that other such examples may exist), together with an indication of any particular challenges.

Assessment categories

Each review team assesses performance using the categories 'met', 'not met' and 'not met (insufficient evidence)', as detailed below.

- '**Met**' applies where the evidence demonstrates the standard and/or criterion is being attained.

- '**Not met**' applies where the evidence demonstrates the standard and/or criterion is not being attained.

- '**Not met (insufficient evidence)**' applies where no evidence is available for the review team, or where the evidence available is insufficient to allow an assessment to be made.

A final category '**not applicable**' is used where a standard and/or criterion does not apply to the NHS board under review.

1.3 Reports

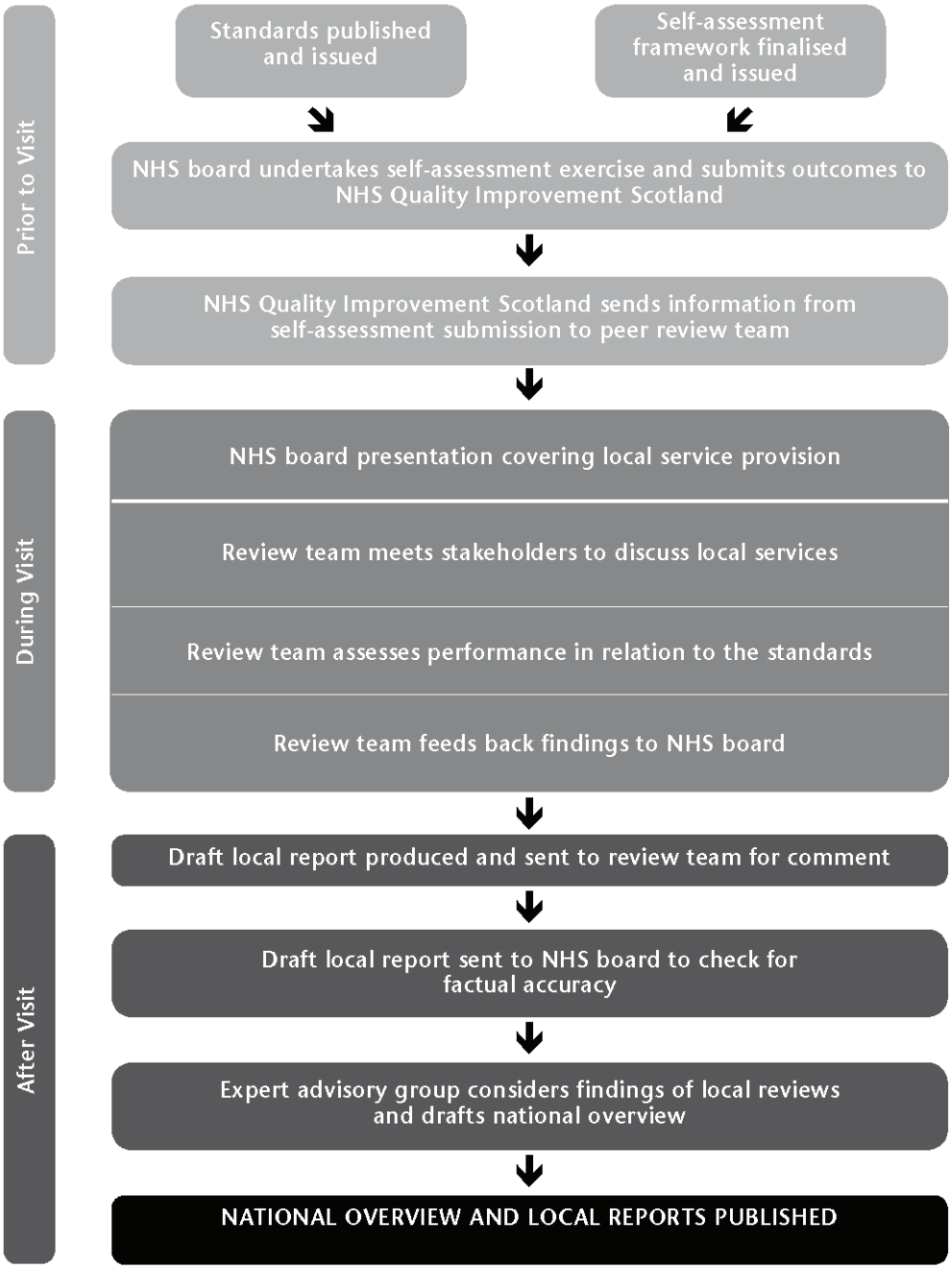
After each review visit, NHS QIS staff, with clinical input as appropriate, draft a local report detailing the findings of the review team. This draft report is sent to the review team for comment, and then to the NHS board to check for factual accuracy. The local report is published only after all the visits for that topic have been undertaken nationwide.

Once a national review cycle is completed, the expert advisory group convenes to examine review findings and make recommendations. The group then oversees the production of a national overview of service provision across Scotland in relation to the standards. This document includes both a summary of the findings (highlighting examples of local initiatives and challenges for the service) and recommendations for improvement.

Part of the remit of NHS QIS is to report whether the services provided by NHSScotland, both nationally and locally, meet the agreed standards. This does not include reviewing the work of individual healthcare professionals. In achieving this aim, variations in practice (and potential quality) within a service will be encountered and subsequently reported.

Please note – all reports published are available in print format and on the NHS QIS website.

The review process



2 Summary of findings

2.1 Overview of local service provision

At the time of the visit, NHS Argyll & Clyde was responsible for an extensive area of west-central Scotland with a population of around 415,658. This is a region of contrasts, where the majority of the population live in densely populated urban areas, some of which have high levels of illness and deprivation. However, a significant proportion of the population live in remote and rural areas and on islands.

Local NHS system and services

Argyll & Clyde NHS Board was responsible for improving the health of the local population and for the delivery of the healthcare required. It provided strategic leadership and had responsibility for the efficient, effective and accountable performance of services.

NHS Argyll & Clyde contained three NHS operating divisions, each of which provide acute and primary care services: Inverclyde Division; Greater Renfrewshire Division; and Lomond & Argyll Division.

An NHS board is accountable for both continuously improving the quality of health services, and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish (framework of clinical governance).

NHS Argyll & Clyde was dissolved on 31 March 2006, and the administrative boundaries of NHS Greater Glasgow and NHS Highland altered to allow them to take over the responsibility for managing the delivery of health services in relevant parts of the Argyll and Clyde area. NHS Highland's extension covers the area of Argyll and Bute Council. The remainder of the area falls within the renamed NHS Greater Glasgow and Clyde.

Further information about the local NHS system can be accessed via the website of NHS Highland (www.show.scot.nhs.uk/nhshighland) and NHS Greater Glasgow and Clyde (www.nhsgg.org.uk/content).

Service organisation

Information obtained from a scoping study exercise undertaken in 2005 indicated that there are 15 NHS boards within Scotland that provide maternity services.

In Argyll & Clyde, all maternity services are provided across primary and secondary care settings throughout the NHS board area, with specialist/tertiary services being provided by NHS Greater Glasgow and Clyde.

There is a consultant-led maternity unit (CLU) and a community maternity unit (CMU) in Royal Alexandra Hospital, Paisley, and a further eight CMUs: Vale of Leven District General Hospital, Alexandria; Inverclyde Royal Hospital, Greenock; Lorne & Islands District General Hospital, Oban; Mid Argyll Hospital,

Lochgilphead; Dunoon General Hospital; Victoria Hospital, Rothesay; Campbeltown Hospital; and Islay Hospital, Bowmore. The number of births have remained static over the last 5 years as illustrated in the following table.

NHS Argyll & Clyde	Number of births				
	2001	2002	2003	2004	2005
Royal Alexandra Hospital (CLU)	1,990	1,931	2,117	3,176	3,034
Royal Alexandra Hospital (CMU)	0	0	0	18	240
Inverclyde Royal Hospital	914	872	773	77	115
Vale of Leven District General Hospital	829	677	32	61	59
Lorne & Islands General Hospital	31	41	56	50	30
Mid Argyll Hospital	14	16	12	20	18
Dunoon General Hospital	31	23	32	30	37
Victoria Hospital	14	15	13	19	20
Campbeltown Hospital	6	5	1	8	15
Islay Hospital	2	1	0	3	2
Home births	5	6	6	15	14
Other (eg born before arrival)	0	0	0	0	0
Total births	**3,836**	**3,587**	**3,042**	**3,477**	**3,584**

2.2 Summary of findings against the standards

A summary of the findings from the review, including examples of local initiatives drawn to the attention of the review team, is presented in this section. A detailed description of performance against the standards/criteria is included in Section 3.

Core Principles

NHS Argyll & Clyde was dissolved on 31 March 2006, and the administrative boundaries of NHS Greater Glasgow and NHS Highland altered to allow them to take over the responsibility for managing the delivery of health services in Argyll & Clyde. There are named individuals in NHS Highland and NHS Greater Glasgow and Clyde who have responsibility for maternity services delivered within the former boundaries of NHS Argyll & Clyde. Both NHS Highland and NHS Greater Glasgow and Clyde have agreed that the NHS Argyll & Clyde maternity services outline business case prepared in 2003 is a basis for a strategy, however, at the time of the review visit, a formal strategy had yet to be documented.

There has been a good record of public involvement in the planning of maternity services within Argyll & Clyde and members of the dissolved maternity services liaison committee (MSLC) are expected to continue to contribute within the restructured Board areas.

An electronic risk management reporting system is used in the majority of maternity units within Argyll & Clyde which assists with the reliable reporting and tracking of all incidents. Learning from incidents is shared across the units in the form of good practice statements and a quarterly clinical incident newsletter. The risk management reporting system is also used to capture maternity service-users' comments and complaints which can lead to improvements in the delivery of services.

Example of a local initiative…

The Scottish Ambulance Service has been, and continues to be, closely involved in the planning of procedures for the transfer of women during pregnancy, childbirth and with their newborn within Argyll & Clyde. Specific CMU practice guidelines which take account of the geography of the region had been agreed between the Scottish Ambulance Service and the former NHS Argyll & Clyde for safe transfers. Liaison with the National Neonatal Transport Service was also reported to be working well.

There is access for women and their babies to a network of specialist services within Argyll & Clyde and referrals to tertiary services in NHS Greater Glasgow and Clyde can be made as appropriate. Formal arrangements for referrals are however, not documented.

Although important aspects of maternity care are audited within Argyll & Clyde, the review team encouraged staff to take a more systematic approach to audit. There is a comprehensive resuscitation training programme which ensures that all healthcare

professionals, from all areas across Argyll & Clyde, who are directly involved in childbirth, have their resuscitation skills regularly updated.

A standardised clinical risk assessment process is in use throughout Argyll & Clyde. This takes account of changes to clinical risk factors throughout a pregnancy and the special needs of women at risk of domestic abuse are also recognised.

Example of a local initiative…

A domestic abuse working group for Renfrewshire, Inverclyde and Lomond commissioned the voluntary organisation Scottish Women's Aid in partnership with Renfrewshire Women's Aid to deliver in-house training for domestic abuse trainers. This training equipped the participants with the skills and knowledge to deliver best practice domestic abuse training to healthcare professionals working in maternity services across Argyll & Clyde.

High dependency and adult intensive care are available in Royal Alexandra Hospital and all women with significant medical or obstetric illness or those developing a high risk pregnancy would be booked to deliver there. Neonatal intensive care is available within the special care baby unit (SCBU) in Royal Alexandra Hospital and these facilities are being reviewed by NHS Greater Glasgow and Clyde for conformance with the British Association of Perinatal Medicine Standards.

There is a named midwife, recorded for each pregnant woman in her handheld maternity record, who takes a key role in giving information to the woman and her partner. The information is available verbally, in written leaflets and in DVD format. The midwife discusses with the woman the choices available for the place of birth of her baby and encourages her to reflect on her birth experience. Midwives receive formal communication skills training to fulfil this role and the review team encouraged medical staff to take advantage of this training too. A survey of the maternity services information given in Argyll & Clyde found that the majority of women were satisfied with its quantity and content. Another survey of visiting hours resulted in changes to the times to ensure that partners and the woman's own family could be better accommodated.

All women have a handheld maternity record, however, it is not yet standardised across Argyll & Clyde and the introduction of the national record (Scottish Woman-Held Maternity Record) will rectify this.

Pre-conception and Very Early Pregnancy

The review team commended the specific pre-conception obstetric/diabetic clinics for women with diabetes and noted that continuous audit against SIGN Guideline 55: Management of Diabetes occurs for all women with diabetes who deliver in Argyll & Clyde. Specialist pre-conception clinics are also available for women with a personal or family history of significant illness.

Formal arrangements are in place for referral to an early pregnancy assessment unit which can also be accessed directly by women who have had problems in previous pregnancies. These units are in dedicated, discrete areas within Royal Alexandra Hospital, Inverclyde Royal Hospital and Vale of Leven District General Hospital.

Pregnancy

There is a comprehensive parent education programme delivered locally throughout Argyll & Clyde which includes giving the Ready, Steady, Baby book at an early stage of pregnancy and holding a postnatal reunion. This programme is overseen by local co-ordinators, however, the review team encouraged staff to nominate a single lead co-ordinator.

There is a screening programme in place which identifies women at risk of rhesus disease and these women are offered Anti-D injections at 28 and 34 weeks. However, it is not always possible to deliver this service in rural areas and a protocol is being developed to address this. Fetal anomaly screening is offered to all women in Argyll & Clyde at 18 weeks.

Antenatal care plans for women in Argyll & Clyde are based on a continuous assessment of risk which allows for movement between different levels of care. The booking process is divided into two visits, the first for information giving and the second for clinical investigations. There are then another eight visits for routine antenatal care for both primigravidae and multigravidae. The review team recommended the staff consider reviewing the necessity of the 36 week visit as the routine pattern of care does not comply with national policy as outlined in 'A Framework for Maternity Services in Scotland'.

Childbirth

All women in Argyll & Clyde receive one-to-one midwifery care during established labour and childbirth, and two midwives are present for planned home births. Guidelines for the management of all key labour practices are readily available and regularly reviewed and updated by a multidisciplinary group.

All women throughout Argyll & Clyde are informed about, and offered, a range of pain management techniques during childbirth including epidural analgesia which is available at all times in Royal Alexandra Hospital. The review team encouraged the Board to start using a validated pain assessment tool during epidural analgesia or operative delivery. During childbirth, all women have access to anaesthesia and there is a system in place to ensure a rapid response to obstetric emergencies.

Postnatal and Parenthood

All women in Argyll & Clyde receive appropriate care and assessment from giving birth to the 6-week postnatal check. Information on contraception is provided within 2 weeks of childbirth.

Argyll & Clyde maternity services promote, support and sustain breastfeeding. Royal Alexandra Hospital and the CMU in Inverclyde Royal Hospital are accredited as UNICEF/WHO Baby Friendly and the other CMUs are working towards

accreditation. A range of information on breastfeeding is provided to women in different formats and local peer support groups are promoted throughout the region.

Example of a local initiative…

A group of local women who have had experience of breastfeeding have prepared a leaflet, Out & About With Your Baby, which gives quality and privacy ratings for premises where breastfeeding can take place and where baby changing facilities are available. The leaflet also indicates whether there is room for toddlers and a buggy, and whether it is acceptable for 'dads' to use the facilities. National breastfeeding helplines and local support group contacts are also included.

All babies are clinically examined immediately following birth and again prior to discharge or within 72 hours of birth. The review team commended the fact that so many midwives are trained in the examination of the newborn. The provision of transitional care facilities for mothers and their newborn would reduce the number of babies that are admitted to the SCBU and staff reported that these facilities were being developed as part of the plan for refurbishment in Royal Alexandra Hospital.

There are guidelines in place for continuing care and the transfer of information on women and their newborn babies when they return into the community.

3 Detailed findings against the standards

Standard 1(a): Standard 1 ~ Core Principles

Standard Statement
Accountability: There are clear lines of responsibility for the planning and delivery of maternity services, with evidence of public involvement.

NHS Argyll & Clyde

Essential Criteria

1a.1: There is a named individual at NHS Board director level with responsibility for maternity services.

STATUS: **Met**

The NHS Highland Board director of nursing has responsibility for Argyll & Bute council area maternity services and the head of nursing (Clyde, Acute) has responsibility for maternity services in the Clyde area, reporting to the Board of NHS Greater Glasgow and Clyde.

1a.2: There is a named clinician at both Primary and Acute NHS Operating Division level with responsibility for maternity services.

STATUS: **Met**

A named consultant obstetrician/gynaecologist and a named midwife have joint responsibility at both Primary and Acute Operating Division levels for maternity services delivered within Argyll & Clyde.

1a.3: There is a current, dated, documented NHS Board strategy, developed by stakeholders, which sets out how maternity services are planned, developed and implemented, in line with Scottish Executive Health Department (SEHD) policies for women-centred care.

STATUS: **Not met**

The review team recognised the work undertaken by the NHS Argyll & Clyde Board to prepare a maternity services outline business case in 2003. Staff reported that this business case is being reviewed in light of the recent dissolution of NHS Argyll & Clyde and the realignment of NHS Board administrative boundaries. Staff reported that the outline business case has been recognised by the Boards of NHS Greater Glasgow and Clyde and NHS Highland to be the basis for a 10-year plan for

maternity services in Argyll & Clyde. However, the review team encouraged Argyll & Clyde staff to progress the production of a formal maternity services strategy document for their divisions.

1a.4: There is evidence of a range of public involvement activities in the planning of all maternity services.

STATUS: **Met**

The review team commended the public involvement work of the Argyll & Clyde maternity services liaison committee (MSLC) which had advised NHS Argyll & Clyde in the planning of all maternity services. In accordance with the Argyll & Clyde restructuring, the MSLC membership will be reviewed and staff reported that it was hoped that the MSLC members (including the members of the public) would continue their local commitment to improving maternity services within their newly allocated NHS Board areas.

Standard 1(b): Standard 1 ~ Core Principles

Standard Statement
Risk Management: All healthcare professionals are aware of the importance of risk assessment and management of pregnant women, and take action to minimise avoidable adverse clinical incidents, including during transfer and access to services.

NHS Argyll & Clyde

Essential Criteria

1b.1: Assessment: There is a system to ensure that all critical incidents are reported, investigated and analysed, resulting in changes in practice, where necessary.

STATUS: **Met**

A multidisciplinary maternity services clinical incident group meets weekly at the Royal Alexandra Hospital, Paisley, and oversees the risk management process. This process encourages the reporting of incidents and ensures that all incidents are tracked and investigated by appropriate personnel, and changes in practice are introduced where necessary.

All staff can complete an IR1 incident report which can remain anonymous. Staff reported that where the forms are completed anonymously, the reporter still records their professional status and forms are received from all staff groups. A senior member of maternity services staff reviews forms locally every day and takes immediate action if required. Forms are then collated for the clinical incident report group who will allocate a risk classification to the incident, assign a review team and if appropriate suggest to the clinical director that an external investigation be set up. The group prepares quarterly reports for Royal Alexandra Hospital clinical governance committee and a monthly summary of incidents for the Argyll & Clyde health governance committee. These monthly data are entered into a Datix risk management reporting system. Staff reported that the Datix system has been installed in some GP practices throughout Argyll & Clyde and the review team encouraged staff to install the Datix in all community maternity units (CMUs). It was also reported that the Datix data will be copied to NHS Highland in the future.

The clinical incident report group also prepares good practice statements and a quarterly clinical incident newsletter which are distributed to staff throughout Argyll & Clyde. The newsletter, which was commended by the review team, is presented in a reader-friendly format and includes an activity report on incidents reviewed and action points resulting from the review.

1b.2: Assessment: A compliments, comments and complaints procedure is in place to enable women to express views about their pregnancy and childbirth experience.

STATUS: **Met**

Within Argyll & Clyde, all comments and complaints are formally processed according to a policy and operating guidelines based on the Scottish Executive NHS complaints procedure (2005) which aims to provide a full response to a complainant within 20 days of receipt of the complaint.

Maternity service-users who wish to make a complaint are encouraged to make contact with the staff who delivered their care and if the complainant is not satisfied with the response they are directed to contact the complaints manager. Contact details for the complaints manager are advertised on posters displayed in Royal Alexandra Hospital and the CMUs. Two information booklets are distributed to all women using maternity services: 'Making a Complaint about the NHS' and 'The NHS and You'.

A single system for dealing with comments and complaints is used throughout Argyll & Clyde. Data on complaints are entered into Datix and quarterly and annual reports are produced for discussion at staff meetings. Midwives feedback to users groups and the MSLC on actions taken as a result of complaints received and use this forum to agree surveys which should be conducted. One such survey concerned visiting hours at Royal Alexandra Hospital maternity unit and resulted in a change to provide hours which better met the needs of women, visitors and staff.

Compliments are not formally analysed, but copies of letters received are distributed to relevant staff.

1b.3: Assessment: There are local guidelines agreed between the NHS Operating Division and the Scottish Ambulance Service, for the safe transfer of women during pregnancy, childbirth and with her newborn baby in the postnatal period.

STATUS: **Met**

Written agreed guidelines are in place between NHS Argyll & Clyde maternity services and the Scottish Ambulance Service. These guidelines exist for the safe transfer of a woman during pregnancy, childbirth and with her newborn baby in the postnatal period. Guidelines are also in place for the emergency transfer of neonates from home to the nearest CMU to await arrival of the National Neonatal Transport Service (Western Region) for transfer to a consultant-led unit (CLU). This response is most likely to be needed in rural areas whereas in urban areas it was noted that transfer by the Scottish Ambulance Service directly to a CLU may be more practical.

Staff reported that review meetings between maternity services and the Scottish Ambulance Service take place quarterly with the head of nursing (Clyde, Acute) acting as liaison.

1b.4: Referral: Formal arrangements exist for women and their babies to access a network of specialist services.

STATUS: **Not met (insufficient evidence)**

The review team was informed that there are referral arrangements for women and their babies to access a network of specialist services across the whole of the Argyll & Clyde region: allied health professions (AHPs); anaesthesia and intensive care (Royal Alexandra Hospital); imaging; laboratory medicine; medicine; neonatology; obstetrics (Royal Alexandra Hospital and outreach clinics at CMUs); surgery and psychiatry. An integrated care pathway for women with mental health problems is being developed and the review team encouraged the maternity services staff to consider using the same assessment scores for the pre and postnatal assessment of mental health.

Specialist scans, eg ventilation perfusion, would be provided at Glasgow Royal Infirmary and perinatal pathology is provided by the Royal Hospital for Sick Children, Glasgow.

While the review team was reassured that the referrals were working in practice they noted that there were no formal arrangements in place.

1b.5: Referral: All women with risk factors for their pregnancy are offered assessment by a consultant obstetrician.

STATUS: **Met**

Risk assessment takes place at a woman's booking visit by her midwife who will refer her to a consultant obstetrician for further assessment if risk factors exist.

1b.6: Training and Audit: There is an audit system in place to monitor important aspects of maternity care.

STATUS: **Met**

Argyll & Clyde maternity services participate in several national multi-centred audits. Local data including birth outcomes and admissions to the special care baby unit (SCBU) in Royal Alexandra Hospital are collected daily and entered into a database. The data are reviewed formally at a multidisciplinary labour ward forum. Perinatal mortality data across Argyll & Clyde are presented to a multidisciplinary perinatal mortality group which meets quarterly and invites external experts to peer review practices.

The review team was presented with evidence of a wide range of audits on important aspects of maternity care and the results of patient satisfaction surveys. Staff advised that the choice of audit topics was ad hoc, other than audits of breastfeeding rates

which took place every six months. The review team encouraged the maternity services staff to take a more systematic approach to audit. The review team also supported the reporting of findings to the relevant clinical effectiveness committees within NHS Highland and NHS Greater Glasgow and Clyde for action planning.

1b.7: Training and Audit: All healthcare professionals directly involved in childbirth are competent in basic adult obstetric, neonatal resuscitation and immediate care.

STATUS: **Not met**

All healthcare professionals directly involved in childbirth receive training in basic adult, obstetric and neonatal resuscitation and attendance is monitored through the annual appraisal process. The majority of healthcare professionals were reported as having completed the relevant training. There is an ongoing midwife training programme in the CMUs which is provided by a resuscitation training officer and/or a paediatrician. Training records are available to record that midwives regularly attend advanced life support in obstetrics (ALSO) and newborn life support (NLS) courses.

Consultants receive basic life support training at a 4-hour morning session and staff reported that, at the time of the review visit, a third of consultants had attended.

Neonatal resuscitation training is included in the ALSO and NLS courses and additional training is provided by the paediatric staff.

The overall provision of such a comprehensive training programme across a region the size of Argyll & Clyde was commended by the review team.

1b.8: Clinical Complications: A clinical risk assessment process for individual women, including a communications strategy, is in place, which addresses escalating risk.

STATUS: **Met**

Risk assessment is ongoing throughout a woman's pregnancy and there are CMU guidelines for appropriate referral should risk increase or decrease. These guidelines are in use across the whole of Argyll & Clyde. Staff reported that NHS Highland has agreed that these arrangements will continue in the Argyll and Bute council area.

1b.9: Clinical Complications: A policy is in place for the identification of women who are at risk of domestic abuse, and staff are trained in assessment, communication skills and support of such women.

STATUS: **Met**

Guidelines assist staff to identify women at risk of domestic abuse and refer them to the Special Needs In Pregnancy Service if appropriate. Leaflets on domestic abuse and contacts for help are available to women in all units.

A multidisciplinary group of healthcare professionals including two midwives recently attended a course on Training for Domestic Abuse Trainers which was delivered by Scottish Women's Aid and Renfrewshire Women's Aid. At the time of the review visit, a full training programme on domestic abuse was being developed for healthcare staff within Argyll & Clyde. The review team noted that a considerable number of midwives and health visitors had already received domestic abuse training.

1b.10: Clinical Complications: High dependency facilities and clinical expertise are available within the obstetric unit for all women in level II and level III consultant-led units.

STATUS: **Met**

High dependency care is provided in a dedicated area of the labour ward in Royal Alexandra Hospital which is the only level II unit in Argyll & Clyde. The labour ward is adjacent to two obstetric theatres and anaesthetic rooms. Midwives who are skilled in caring for high-risk women work in the high dependency area and receive refresher courses on intensive care monitoring. Dedicated anaesthetic nurses set up the intensive care monitoring equipment and support the midwives in the high dependency area.

A dedicated obstetric anaesthetist and an experienced obstetrician are resident on the labour ward 24 hours a day with a consultant obstetrician on-call. A consultant obstetric anaesthetist is also named as the lead for obstetric services.

1b.11: Clinical Complications: There is a defined rapid access route for women to adult intensive care and expertise in all level II and level III consultant-led units.

STATUS: **Met**

The lead consultant anaesthetist and a consultant obstetrician would decide whether a woman should be transferred to adult intensive care from the high dependency area in Royal Alexandra Hospital. The woman would be stabilised in the obstetric theatre or labour ward and then transferred with appropriate equipment and an escort to the adult intensive care facilities which are close by.

1b.12: Clinical Complications: Adult intensive care facilities and specialist medical back-up are available on-site in all level IIc and level III consultant-led units.

STATUS: **Met**

A seven-bedded adult intensive care facility is available in Royal Alexandra Hospital adjacent to the main theatre suite. It was confirmed that this facility is fully equipped, with specialised intensive care staff available 24-hours a day. There is a dedicated family room for use by visitors.

1b.13: Clinical Complications: Where full adult intensive care facilities are not currently available on-site in level IIc and level III consultant-led units, a strategy is in place outlining the process and timescale to achieve this.

STATUS: **Not applicable**

Royal Alexandra Hospital is a level II consultant-led service which provides full adult intensive care facilities on-site.

1b.14: Clinical Complications: Units that do not have adult intensive care facilities, advanced imaging and cardiology on-site, must have protocols in place for the care of women with significant medical or obstetric illness to ensure that they are delivered in a unit that can provide these resources on-site.

STATUS: **Met**

Within Argyll & Clyde, only the Royal Alexandra Hospital has adult intensive care facilities, advanced imaging and cardiology on-site. All women with significant medical or obstetric illness or those developing risk factors during their pregnancy would be directed to book to deliver at the Royal Alexandra Hospital. Those women who are booked to deliver in a CMU or at home and who develop complications during labour would be transferred to the nearest CLU.

1b.15: Clinical Complications: Neonatal intensive care unit (NICU) facilities are available on-site in level llc and level lll consultant-led units. Where NICU facilities are not available on-site, a strategy is in place outlining the process and timescale to achieve this.

STATUS: **Met**

There are four intensive care cots in a separate room within the SCBU in Royal Alexandra Hospital. When it is anticipated that a baby may require intensive care and an intensive care cot is not available arrangements are made to transfer the woman to the nearest unit with an intensive care cot available. If a baby requires intensive care

and a cot is not available, the baby would be stabilised locally and transfer arranged using the neonatal transport service.

There is an experienced paediatrician resident on the SCBU and a consultant on-call 24 hours a day to cover the SCBU and paediatrics. In addition to midwives, general nurses and neonatal nurses, there are four advanced neonatal nurse practitioners and another one in training, with a vacancy for another under consideration.

The paediatrician visits the postnatal wards daily and there is a fast-bleep system to call them in case of an emergency, which is tested on every shift.

1b.16: Clinical Complications: Special care baby unit (SCBU) facilities are available on-site in all level II and level III consultant-led units and there is a defined rapid access route to NICU in all level II and level III consultant-led units.

STATUS: **Met**

There are 16 special care cots in the SCBU in Royal Alexandra Hospital. Babies can be transferred to the SCBU for observation for up to 4 hours and return to their mother in the postnatal ward if observations are normal. If the observations are not normal after 4 hours, the baby would be fully admitted to the SCBU. At the time of the review visit, transitional care facilities were being developed as part of a refurbishment plan for the maternity unit.

When it is anticipated that a baby may require special care and a special care cot is not available, arrangements are made to transfer the baby to the nearest unit with a special care cot available. If a baby requires special care and a cot is not available the baby would be stabilised locally and transfer arranged using the neonatal transport service.

1b.17: Clinical Complications: Where there is provision of NICU and SCBU facilities, these conform to agreed national guidelines.

STATUS: **Not met**

At the time of the review, staff reported that NHS Greater Glasgow and Clyde was developing a set of guidelines for all SCBU and neonatal intensive care unit (NICU) facilities to ensure they meet agreed national guidelines. A representative from Royal Alexandra Hospital SCBU will be involved in the group developing these guidelines. An action plan has already been prepared to address all areas where the Royal Alexandra Hospital SCBU does not meet the British Association of Perinatal Medicine standards and ways of meeting the required neonatal staffing levels are being considered.

Standard 1(c): Standard 1 ~ Core Principles

Standard Statement
Information, Communication and Support: All women are fully informed of the different options available to enable them to take an informed and active role in planning their care, and in the decision-making involved in providing this care. Healthcare professionals are skilled in supporting women in the decision-making process.

NHS Argyll & Clyde

Essential Criteria

1c.1: There is a named healthcare professional identified for each woman, who leads and plans her contact with maternity services.

STATUS: **Met**

All pregnant women within Argyll & Clyde have a named midwife recorded in their handheld maternity record and booking assessment form.

1c.2: Women are provided with information in order to make an informed decision about the chosen place of birth for their baby.

STATUS: **Met**

The Royal Alexandra Hospital maternity services guide, which explains choices for place of birth, is given to all women in Argyll & Clyde. All other CMUs have leaflets describing choices for place of birth available which include: home birth; the local CMU and the CLU in Royal Alexandra Hospital; The Queen Mother's Hospital, Glasgow; and the Southern General Hospital Maternity Unit, Glasgow. This information is also provided verbally by midwives at each visit and during parent education classes. Translation and sign language services can be readily accessed. Information about the maternity unit at Royal Alexandra Hospital is also available in DVD format and the Rothesay users group have prepared a DVD with information on the CLU within Royal Alexandra Hospital.

Women with learning disabilities or communication difficulties would be referred to the special needs in pregnancy service and receive information on choices for place of birth in a one-to-one session. Within Royal Alexandra Hospital a 'Family Matters' midwife would arrange an individualised session for women with special needs and would involve other care professionals as required.

Suitable procedures are in place to ensure that further information and consultation can take place if women are denied their first choice of place of birth for their baby based on their risk assessment. The review team commended the provision of information on the woman's right to choose the place of birth for her baby and the efforts made to support this choice without compromising safety.

1c.3: There is evidence that professionals obtain informed consent for interventions and investigations, and this is documented.

STATUS: **Met**

There is a comprehensive Argyll & Clyde consent policy and framework for interventions and investigations, and the verbal and written provision of consent is documented in the handheld maternity record. Written consents are required for antenatal blood screening, neonatal blood screening and elective caesarean sections. In emergency situations the lead healthcare professional would fully inform the woman and check her understanding before proceeding with an invasive procedure. This verbal consent would be documented in the handheld maternity record as would withholding of consent.

1c.4: All women are given the opportunity to reflect on their birth experience.

STATUS: **Met**

Across Argyll & Clyde, all women are given the opportunity to reflect on their birth experience as part of routine midwifery care. A discussion usually takes place in the woman's home during the first postnatal visit or whilst the woman is still in hospital.

Dedicated sessions for review and reflection with their obstetric consultant are given to those women who experienced a complicated labour, third degree tear or perinatal loss or morbidity.

1c.5: Training on how to communicate information in an effective and sensitive manner, is provided to all healthcare professionals.

STATUS: **Met**

All new maternity services staff within Argyll & Clyde have a session on communication training as part of their induction. Nursing and midwifery staff and nursing auxiliary staff have their communication skills assessed formally on an annual basis as this forms part of their knowledge and skills framework. Training needs in communication skills might also be identified during incident reviews, and peer support would be provided to address this. Medical staff receive communication skills training as students and during their induction training, however, there is no formal ongoing training programme for them. The review team encouraged medical staff to update their communication skills on a formal basis.

1c.6: There is a policy for supporting and informing parents bereaved during pregnancy, or soon after giving birth.

STATUS: **Met**

A staff information package on miscarriage, stillbirth, and neonatal death is readily available in all units and staff are advised whenever the contents change. This contains checklists for information-giving to help staff support parents bereaved during pregnancy or soon after birth. The information is given verbally and in a variety of leaflets. Staff also reported that there are good links with the Stillbirth and Neonatal Death Society (SANDS) whose local Lomond leaflet is also distributed. On a woman's discharge, the checklist is shared with the woman's GP and community midwife to ensure continuing care.

All new staff attend a training course for professionals on the management of pregnancy loss and the death of a baby. This course is conducted at least annually.

1c.7: Information giving (verbal, written and other media) is monitored and evaluated.

STATUS: **Met**

Professionals and user groups and a non-professional member of the maternity team review new or revised information leaflets before they are printed and comments on the information provided are encouraged.

A survey on the information given by midwives was conducted in early 2006 and indicated that the majority of women who responded were happy with the amount of information given.

Standard 1(d): Standard 1 ~ Core Principles

Standard Statement
Partner and Family Involvement: All maternity services and healthcare professionals recognise the important role of the partner/family, and ensure that they are encouraged and supported to be involved in pregnancy and childbirth.

NHS Argyll & Clyde

Essential Criterion

1d.1: There is evidence that partner/family/friend involvement occurs, (including information provision for partners and families and open/flexible visiting times for partners and children).

STATUS: **Met**

Midwives within Argyll & Clyde encourage partners to attend antenatal and postnatal education classes and accommodation can be provided for them if the woman is admitted to Royal Alexandra Hospital as an emergency. Birth partners are encouraged to be present during labour and at caesarean section. This involvement is promoted in written information leaflets.

Following a visitor survey, visiting hours in Royal Alexandra Hospital for partners and the woman's own children were extended from 12.30-9pm, or by special arrangement if this is unsuitable. CMU visiting hours are flexible in line with the woman's wishes.

Standard 1(e): Standard 1 ~ Core Principles

Standard Statement
Record-keeping: A structured and accurate record of all events during the antenatal, childbirth and postnatal periods is maintained for every woman and child (known as a 'unified record').

NHS Argyll & Clyde

Essential Criteria

1e.1: All women have a unified handheld record.

STATUS: **Met**

Women have a unified handheld maternity record, though some sections are not yet standardised across the whole of Argyll & Clyde.

1e.2: The SMR02, Scottish birth record and birth notification General Register Office for Scotland (GROS), is completed for all women and newborn babies in line with current standards.

STATUS: **Met**

There is a process in place across Argyll & Clyde to ensure that the SMR02, Scottish birth record (SBR) and birth notification General Register Office for Scotland (GROS) are completed in line with current standards. The midwife in attendance at delivery completes a birth notification. The information from this notification is then used to complete the SBR and entered into the electronic patient administration system which generates the SMR02. The receiving midwife will complete the birth notification if a baby is born before arrival at the CMU or CLU and a midwife is not present.

Desirable Criterion

1e.3: The national unified handheld record and national electronic record are completed for all women and newborn babies.

STATUS: **Not applicable**

The review visit to NHS Argyll & Clyde took place shortly after the official launch of the national unified handheld maternity record. As the review team considered the time between the launch of the national record and this review visit to be insufficient to measure progress in this area, it concluded this criterion was not applicable at this stage of the review process.

Standard 2(a): Standard 2 ~ Pre-conception and Very Early Pregnancy

Standard Statement
Pre-conception Services: All women with a poor obstetric/medical history, a previous poor fetal/maternal outcome, or where there is a family history of significant illness, have access to specific pre-conception services.

NHS Argyll & Clyde

Essential Criterion

2a.1: There is a specific pre-conception service for women with diabetes which is based on the SIGN guideline for diabetes.

STATUS: **Met**

A wide range of information leaflets is available in Argyll & Clyde for women with diabetes who are planning a pregnancy. These leaflets would normally be given to a woman at their local general diabetic clinic. The diabetes specialist nurse or consultant would offer the woman the opportunity to attend one of the specialist combined obstetric/diabetic clinics which are conducted in Royal Alexandra Hospital, Inverclyde Royal Hospital, and Vale of Leven District General Hospital. Posters about the combined pre-conception service for women with diabetes are displayed in all diabetic clinics, GP surgeries and maternity units in Argyll & Clyde. A woman with diabetes can be referred to the combined clinic from her local diabetic clinic, her GP or she can self-refer.

This specific pre-conception service is based on SIGN Guideline 55: Management of Diabetes and the review team noted that a continuous audit of compliance with this guideline is carried out for all women with diabetes who deliver in Argyll & Clyde.

Desirable Criterion

2a.2: There are specific pre-conception services for women with a personal or family history of significant illness (eg epilepsy, neural tube defect, chromosomal abnormality).

STATUS: **Met**

There are two specialist pre-conception and antenatal care clinics for women with a personal or family history of significant medical illness. Posters advising women of this service are displayed in GP surgeries and maternity units throughout Argyll & Clyde. The clinics are based in Inverclyde Royal Hospital and Royal Alexandra Hospital and women can be referred by their GP, midwife, obstetrician or hospital consultant.

Standard 2(b): Standard 2 ~ Pre-conception and Very Early Pregnancy

Standard Statement
Early Pregnancy Complications: All women who experience complications in early pregnancy have access to an early pregnancy assessment service.

NHS Argyll & Clyde

Essential Criteria

2b.1: There are formal arrangements in place for referral to the early pregnancy assessment service, which allows any healthcare professional to access the service directly.

STATUS: **Met**

An early pregnancy assessment service (EPAS) is available at Royal Alexandra Hospital, Inverclyde Royal Hospital and Vale of Leven District General Hospital. The service is open on weekdays from 9am–5pm. Women can self-refer or be referred by a midwife, NHS 24, GP or other healthcare professional. Referrals are by telephone and all calls are documented. Staff receiving the call will use an assessment tool to determine whether a woman requires to be seen immediately or whether she can wait to receive an appointment in EPAS the next working day.

2b.2: There are formal arrangements in place for referral to the early pregnancy assessment service, which allows women with previous early pregnancy problems to self-refer.

STATUS: **Met**

Women who have had previous early pregnancy problems are advised that they may contact EPAS at any time if they have bleeding or any other concerns.

2b.3: Women who experience early pregnancy complications are cared for in a dedicated area distinct from the general gynaecology or antenatal ward.

STATUS: **Met**

The early pregnancy assessment units all have dedicated clinic times, waiting areas and facilities separate from the general gynaecology or antenatal wards.

2b.4: Women who miscarry have access to a choice of management options (surgical/medical/expectant).

STATUS: **Met**

Women who miscarry have access to three options for management: surgical, medical and expectant.

Written guidelines are in place for the diagnosis of miscarriage and the three management options.

2b.5: There is prompt access (within 24 hours) to ultrasound facilities with trained staff in secondary and tertiary services.

STATUS: **Not met**

There are dedicated ultrasound facilities with trained staff in the early pregnancy assessment units in Royal Alexandra Hospital, Inverclyde Royal Hospital and Vale of Leven District General Hospital. Ultrasonographers provide this service on weekdays from 9am–5pm. At the time of the visit there was no dedicated out-of-hours scanning service provided, however, staff reported that, where possible, ultrasound scanning would be made available if the medical member of staff on duty was trained in diagnostic scanning.

Desirable Criterion

2b.6: Telemedicine is used to promote regional networking, and to expedite the reporting of results.

STATUS: **Not met**

Results of investigations can be directly accessed from the rural units through the Scottish Care Information programme. Women who are booked to deliver in the peripheral CMUs are at low risk and any women whose risk increased would be transferred to a CLU so staff perceive there is little need or advantage to having regional telemedicine links.

Standard 3(a): Standard 3 ~ Pregnancy

Standard Statement
Education Programme: All maternity services provide comprehensive programmes of education for childbirth and parenthood to women and their partners and families.

NHS Argyll & Clyde

Essential Criteria

3a.1: There is a written syllabus of education that targets specific groups, and is in a user-friendly format. The syllabus outlines the aims, themes and outcomes of the education programme.

STATUS: **Met**

Argyll & Clyde has documented the aims and outcomes for their parent education programme with syllabuses tailored within local areas provided from Royal Alexandra Hospital; Vale of Leven District General Hospital; Inverclyde Royal Hospital; Lorne & Islands District General Hospital, Oban; Campbeltown Hospital; Mid Argyll Hospital, Lochgilphead; Dunoon General Hospital and Victoria Hospital, Rothesay.

Each syllabus outlines the aims, themes and outcomes of the education programme. Sessions are run at differing times to allow for the attendance of partners, and feedback questionnaires and focus groups are used to continue to refine the programme to suit local needs.

Tailored classes are conducted for first-time parents in all areas and special needs are addressed with one-to-one education. The review team noted that each syllabus was comprehensive and in particular noted the educational work done by midwives for young pregnant women and teenage parents in collaboration with Barnardo's Paisley Threads: Prenatal Drop-in Centre.

3a.2: There is a lead named co-ordinator, with recognised training and development to undertake the role, who takes responsibility for the programme on a service-wide basis.

STATUS: **Not met**

There is a lead education programme co-ordinator in each of the eight educational regions within Argyll & Clyde. They are all midwives with differing areas of educational expertise and two have taken additional recognised training for their role. Staff reported that the co-ordinators regularly network by email and telephone, however, the review team emphasised the benefits of a single lead co-ordinator.

Desirable Criteria

3a.3: The Ready, Steady, Baby book is provided to all women on confirmation of pregnancy.

STATUS: **Met**

The Ready, Steady, Baby book is given to all pregnant women in Argyll & Clyde at their booking visit with their midwife. The provision of the book is documented on the booking assessment form which is in use across Argyll & Clyde.

3a.4: Parent education programmes include a postnatal reunion.

STATUS: **Met**

Postnatal reunion groups are held in all areas of Argyll & Clyde. The reunion forms part of postnatal exercise classes or in some areas women are invited to attend a specific postnatal reunion session.

Standard 3(b): Standard 3 ~ Pregnancy

Standard Statement
Screening Services: All women have access to screening services and antenatal diagnostic testing.

NHS Argyll & Clyde

Essential Criteria

3b.1: All women who are identified in the screening programme as at risk of rhesus disease are managed and treated according to an agreed protocol.

STATUS: **Not met**

Within Argyll & Clyde, women who are identified in the screening programme as being at risk of rhesus disease are provided with an information leaflet and offered Anti-D injections at 28 and 34 weeks. As the Anti-D has to be prescribed, this is not always possible in rural areas and, at the time of the review visit, a protocol for Anti-D administration which could be followed in a community setting was being developed.

3b.2: The antenatal care and investigation of women conforms to the guidance set out in Table 14, page 40 of A Framework for Maternity Services in Scotland.

STATUS: **Not met**

Across Argyll & Clyde, the first antenatal visit a woman receives from her midwife is considered to be for information-giving purposes only and a second visit is arranged for booking bloods, dating ultrasound and other investigations as described in 'A Framework for Maternity Services in Scotland'. This split-booking was considered to be good practice by the review team. Fetal anomaly screening is offered to all women at 18 weeks. Another deviation from the Framework guidance was an additional visit at 36 weeks for multigravidae. This is discussed further under criterion 3c.3.

Standard 3(c): Standard 3 ~ Pregnancy

Standard Statement
Antenatal Care: All maternity services provide antenatal care delivered by a network of professionals, such that each woman is managed by a midwife, GP or obstetrician according to her level of risk, and as locally as possible.

NHS Argyll & Clyde

Essential Criteria

3c.1: Each maternity service has an explicit plan for antenatal care for all women, taking account of risk, which acknowledges that women can move in either direction between different levels of care and lead professionals.

STATUS: **Met**

All women within Argyll & Clyde have their risk assessed at their booking visit and again at each antenatal visit. There is a flexible care plan to ensure that women can move between different care levels appropriate to their level of risk according to clearly defined criteria. Staff reported that any movement between lead professionals works well in both directions.

There are strict criteria for booking to deliver in a CMU and staff reported that the same criteria are applied for booking into the CMU in Royal Alexandra Hospital even though it was situated alongside the CLU and a fast transfer could be initiated if risk suddenly increased. The review team noted that a more flexible approach to booking criteria in use for the CMU in Royal Alexandra Hospital, CMUs in peripheral areas and CMUs in rural areas would ensure that more women could have midwife-led care without compromising their safety.

3c.2: Women are offered the opportunity to be involved in the development of their birth plan, including the chosen place of birth of their baby.

STATUS: **Met**

All women within Argyll & Clyde are offered a choice of place of birth of their baby and are encouraged to discuss this with their midwife. Women at low risk can choose between a home birth, birth in their local CMU or the CMU in Royal Alexandra Hospital. Women at higher risk are booked into the CLU.

Women booked into Royal Alexandra Hospital receive, with their booking pack, a leaflet which has a series of questions about their preferences for labour and birth. Women are encouraged to discuss their preferred place of birth for their baby with their birthing partner, their family and their midwife. In areas other than Royal Alexandra Hospital, the Ready, Steady, Baby book is used as a resource to prompt discussion about birth plans.

Staff reported that women who may have opted for a home birth are more likely to opt for delivery in a CMU because of the birthing pool facility. It was also reported that in rare cases where high risk women were definite in their choice of home birth that staff could respond to provide care in the woman's home.

3c.3: The routine pattern of antenatal care for pregnant women is no more than nine visits for a primigravida and eight visits for a multigravida.

STATUS: **Not met**

Allowing for the first two antenatal visits to be 'counted' as one visit, the total number of antenatal visits in Argyll & Clyde, for routine care for a primigravida, is nine. For a multigravida, the total number of visits for routine care is also nine. Staff explained that the 36 week visit was additional to the visits set out in 'A Framework for Maternity Services in Scotland'. This visit was introduced to monitor for intrauterine growth retardation and provides an opportunity for detailed discussion of the woman's birth plan. The visit also allows for an opportunity to identify and turn a breech presentation baby if the breech presentation had not been detected before. The review team recommended the staff consider reviewing the necessity of this additional visit.

Standard 4(a): Standard 4 ~ Childbirth

Standard Statement
Care Planning and Birth: All women receive an agreed plan of care throughout labour in line with current professional standards consistent with their risk assessment and their chosen place for childbirth.

NHS Argyll & Clyde

Essential Criteria

4a.1: Each woman receives one-to-one midwifery care during established labour and childbirth by a trained midwife, or trainee midwife under supervision.

STATUS: **Met**

Workforce planning for NHS Argyll & Clyde was done prior to a maternity services review in 2003 and took into account the need for one-to-one midwifery care during labour and childbirth. All women receive one-to-one care and any exceptions would be reported as a clinical incident. The achievement of one-to-one care was commended by the review team. A Birthrate Plus workforce planning review has been completed and an exercise was ongoing to ensure that staff are deployed appropriately.

4a.2: For planned home births there is a minimum of two trained professionals present, one of whom is a midwife.

STATUS: **Met**

An on-call rota of two midwives is prepared from week 38 of pregnancy for each planned home birth. One midwife will be a senior midwife and at least one would be proficient in maternal and neonatal resuscitation. For planned home births in rural areas, midwives would have to stay locally until the birth.

4a.3: There are agreed multidisciplinary, evidence-based policies for the management of all key labour practices, when care deviates from the norm.

STATUS: **Met**

Argyll & Clyde maternity services have agreed multidisciplinary guidelines for all key labour practices for use in the CMUs and CLU. These include: induction of labour; breech presentation; perineal repair; caesarean section; prophylactic antibiotics for caesarean section; placenta praevia; prostaglandins and oxytocin use; management of thromboembolism and thromboprophylaxis; water birth; epidural analgesia; fetal monitoring; management of multiple pregnancy; diabetes; pre-eclampsia and

eclampsia; declination of blood products; haemorrhage; prolapsed cord; rupture of the uterus; shoulder dystocia; neonatal resuscitation; adult resuscitation; retained placenta; and intrauterine death.

The guidelines are drawn up by multidisciplinary groups which meet every 4–6 weeks and update the guidelines on an ongoing basis. Guidelines would be updated in line with national publications or following clinical incident reviews. Each guideline is reviewed within a maximum of a 2-year period. The guidelines are in paper format and held together in one folder in all clinical areas. A pocket-sized booklet of guidelines for obstetrics and gynaecology is also available.

Standard 4(b): Standard 4 ~ Childbirth

Standard Statement
Pain Management: All women, regardless of their specific location, are informed about, and offered the range of pain management techniques during childbirth, and are supported in their choice of pain control.

NHS Argyll & Clyde

Essential Criteria

4b.1: All women receive information about, and have access to, a range of pain management techniques which include: transcutaneous electrical nerve stimulation (TENS); oral and intramuscular analgesia; inhalational analgesia; and the use of water for pain relief. Epidural analgesia is available in consultant-led units.

STATUS: **Met**

The Ready, Steady, Baby book provides information on pain management techniques and a checkbox on the booking assessment form helps ensure that all women receive a copy. Pain relief is also covered at antenatal classes and in one-to-one discussion between a woman and her midwife during the development of the birth plan. A range of nationally produced leaflets are also available.

Women have access to transcutaneous electrical nerve stimulation (TENS); oral and intramuscular analgesia; inhalational analgesia; and the use of water for pain relief. Epidural analgesia is available in Royal Alexandra Hospital.

4b.2: All women, who have epidural analgesia or an operative delivery, have their pain assessed using a pain assessment tool.

STATUS: **Not met**

Although all women who have epidural analgesia or an operative delivery are asked to assess their pain, this is not given a formal score. The review team encouraged the use of a validated pain assessment tool.

Desirable Criterion

4b.3: Epidural analgesia is available at all times in consultant-led units.

STATUS: **Met**

Within Royal Alexandra Hospital, epidural analgesia is available at all times with a general consultant anaesthetist on-call to cover maternity services overnight and at weekends.

Standard 4(c): Standard 4 ~ Childbirth

Standard Statement
Anaesthesia: During childbirth all women have access to anaesthesia that conforms to current professional standards.

NHS Argyll & Clyde

Essential Criteria

4c.1: There is a lead consultant obstetric anaesthetist with responsibility for the organisation and management of the specialist anaesthetics service within consultant-led units.

STATUS: **Met**

The clinical director for anaesthesia services and the lead consultant for obstetric anaesthesia have responsibility for the organisation and management of anaesthesia delivery within maternity services.

4c.2: Arrangements are in place in consultant-led units, to ensure that a specialist anaesthetic service is available at all times during childbirth.

STATUS: **Met**

A dedicated obstetric anaesthetist is available at all times supported by anaesthetic assistants. A dedicated obstetric anaesthetist is also available Monday–Friday for elective caesarean sections, supported by anaesthetic assistants. The anaesthetic assistants are all nurses who are dedicated to the obstetric service.

4c.3: All specialist anaesthetic services comply with NHS QIS anaesthesia standards and Royal College of Anaesthetists (RCA) guidelines.

STATUS: **Met**

The review team acknowledged the Board's commitment to comply with the NHS QIS anaesthesia standards and the guidelines issued by the Royal College of Anaesthetists (RCA). The Board has an action plan to follow-up on the NHS QIS anaesthesia review visit in January 2005. The review team confirmed from observation of this plan that progress has been made and encouraged completion of the actions identified.

4c.4: There is a system in place to ensure that anaesthetic and theatre services respond rapidly to obstetric emergencies and expedite delivery in the event of maternal or fetal compromise.

STATUS: **Met**

In Royal Alexandra Hospital, there are two obstetric theatres adjacent to the labour ward with a dedicated obstetric anaesthetist and anaesthesia assistant nurse on-site at all times. The theatres are always on standby and a paging system for anaesthetists is in use in case of emergencies.

4c.5: There is a system in place to ensure that 'decision to delivery' intervals and perceived urgency are monitored.

STATUS: **Met**

A form is completed by the surgeon for each caesarean section which records the reason for the surgery and its classification of urgency. The data from these forms are summarised and reviewed every month at a labour ward meeting.

Desirable Criterion

4c.6: The time from informing the anaesthetist to the start of an emergency operative delivery should not normally exceed 30 minutes except if there is a risk to maternal health.

STATUS: **Met**

The actual time for 'decision to delivery' is recorded on the form that is used to record the reason for a caesarean section and does not normally exceed 30 minutes. All emergency cases would be considered as clinical incidents and if the decision to delivery interval did exceed 30 minutes, this would be reviewed accordingly.

Standard 5(a): Standard 5 ~ Postnatal and Parenthood

Standard Statement
Care of Women: All women receive appropriate care and assessment from giving birth to the 6-week postnatal check.

NHS Argyll & Clyde

Essential Criteria

5a.1: All women are assessed immediately after giving birth by a suitably qualified member of the birth team.

STATUS: **Met**

All women giving birth in Argyll & Clyde are assessed immediately after birth and observations recorded in their handheld maternity record. The assessment will be conducted by a midwife, obstetrician or anaesthetist as appropriate. The completion of the record is reviewed on transfer to postnatal care.

5a.2: All women are assessed prior to transfer to community care and/or within 24 hours of giving birth, by a midwife.

STATUS: **Met**

All women who give birth in the CLU remain there until their discharge and are examined by a midwife within 24 hours of giving birth and prior to discharge. All care, observations and advice given to women are documented in their handheld maternity record.

5a.3: There is ongoing assessment for the recognition of complications, eg infection, haemorrhage, thromboembolism and anaesthetic problems.

STATUS: **Met**

An individual postnatal care plan is prepared for each woman who delivers within Argyll & Clyde. The plan follows a pro-forma for either a vaginal delivery or an operative delivery. Midwives routinely provide postnatal care and can consult with or refer to members of the multidisciplinary team as appropriate.

5a.4: Women receive information on contraception within 2 weeks of childbirth.

STATUS: **Met**

All women who deliver within Argyll & Clyde receive information on contraception within 2 weeks of childbirth. This information is given verbally by midwives as part of discharge planning and a variety of nationally produced leaflets are available in all postnatal areas or from home-visiting midwives. The discharge discussion on contraception is recorded in the handheld maternity record. Women are also advised of how to access family planning services in their own local area.

Standard 5(b): Standard 5 ~ Postnatal and Parenthood

Standard Statement
Infant Feeding: Maternity services promote, support and sustain breastfeeding. Women are informed of its benefits, while being supported in their chosen mode of feeding.

NHS Argyll & Clyde

Essential Criteria

5b.1: There is evidence that the maternity service adheres to the principles of, or is working towards, the UNICEF/WHO Baby Friendly status.

STATUS: **Met**

The CLU and the CMU within Royal Alexandra Hospital are both accredited as Baby Friendly as is the CMU in Inverclyde Royal Hospital. The other seven CMUs are working towards Baby Friendly status and, at the time of the review, an assessment date of December 2006 had been set by the UNICEF/WHO UK Baby Friendly Initiative. The review team recognised the challenge for Argyll & Clyde maternity services to apply the Baby Friendly principles in the primary care setting and encouraged their work towards the accreditation of the CMUs.

5b.2: Women are provided with readily accessible information and support in their chosen method of feeding, including access to peer support groups.

STATUS: **Met**

Argyll & Clyde midwives give women a range of written information on breastfeeding at their booking visit. This pack includes national leaflets and locally produced leaflets with contact details of support groups and 'breastfeeding-friendly places'. Further information is given at antenatal classes and may include visual aids and videos. Some of these antenatal classes are attended by breastfeeding mothers who share their experiences of breastfeeding. Women are, however, not encouraged to choose their method of feeding until after the birth of their baby and 'skin to skin' contact has been established.

During the postnatal period, women are provided with written guidance on preparing a bottle feed as well as further information leaflets on breastfeeding and local breastfeeding support groups, contact details for a breastfeeding support line, National Childbirth Trust (NCT) and a 24-hour advice line via their local CMU. The support groups are also advertised on posters within CMUs and business-card sized NCT contact cards are available in the postnatal area of Royal Alexandra Hospital.

When women return home they are supported by their midwife and health visitor and are reminded of all the various support groups. A leaflet on breastfeeding and baby changing facilities in the Paisley, Renfrew, Dumbarton and Glasgow areas is also made available. Volunteers visited and rated all the premises listed in the leaflet and the review team noted this good example of supporting breastfeeding women in the community.

Desirable Criteria

5b.3: Each NHS Board area has an infant feeding advisor to provide education and training to healthcare professionals who support women in their chosen method of feeding.

STATUS: **Met**

The senior health promotion officer for nutrition is the infant feeding advisor for Argyll & Clyde maternity services. There is a 2-day training course on breastfeeding for all new maternity services healthcare professionals which is followed-up every 6 months with sessions on updates to breastfeeding policy and practice.

5b.4: Admission rates for babies due to inadequate nutrition are monitored.

STATUS: **Met**

The number of babies under one year old with feeding problems admitted to Royal Alexandra Hospital is recorded and monitored.

Standard 5(c): Standard 5 ~ Postnatal and Parenthood

Standard Statement
Care of Babies: All babies receive appropriate care and assessment from birth until 6 weeks post birth.

NHS Argyll & Clyde

Essential Criteria

5c.1: Steps are taken to minimise the number of infants who require re-warming or avoidable admission to SCBU.

STATUS: **Not met**

Heat loss in the newborn is prevented by taking several steps to maintain the room and cot temperature and by drying babies and by checking their temperature when they are exposed to temperature changes. 'Skin to skin' contact is encouraged and all babies are offered a feed within 1 hour of birth.

The review team noted the facility for observing babies in the SCBU for up to 4 hours without having to fully admit them, however, this does require separation of mother and baby. At the time of the review visit, transitional care facilities were being developed as part of a refurbishment plan for the maternity unit.

5c.2: All babies are clinically examined immediately following birth by a suitably qualified member of the birth team.

STATUS: **Met**

Within Argyll & Clyde, the midwife in attendance at a birth will examine the baby within an hour of birth and refer any abnormalities found to a paediatrician. A record of the examination and findings is kept in the baby's notes.

5c.3: All babies are clinically examined prior to discharge from hospital and/or within 72 hours of birth, by a suitably qualified healthcare professional.

STATUS: **Met**

The majority of midwives within Argyll & Clyde have been trained to conduct the routine examination of the newborn and there is a training programme in place for those not yet trained. Midwives from rural areas spend about a week in the CLU and carry out all the newborn examinations in order to increase their skills. The review team highlighted the significant commitment from maternity services to this training.

The newborn examination takes place prior to discharge from the maternity unit or within 72 hours of birth. There are referral guidelines for the most frequently observed conditions and all observations are recorded in a neonatal record.

5c.4: There is ongoing assessment, including recognition of group B streptococcal infection and jaundice.

STATUS: **Met**

There is a detailed guideline for ongoing assessment of the newborn which includes the prevention of early onset group B streptococcal infection based on the woman's and the baby's risk assessments. Staff reported that, where judged clinically appropriate, women and their babies could be transferred from CMUs to the CLU for antibiotic treatment.

Within Argyll & Clyde, there is a guideline for the detection and assessment of jaundice in the newborn with referral pathways from CMUs to the CLU should phototherapy be indicated. A multidisciplinary group which has been established between the maternity services of the former NHS Greater Glasgow, and the Clyde area of the former NHS Argyll & Clyde has developed a special chart for plotting baby bilirubin levels which has standardised care in this area.

Standard 5(d): Standard 5 ~ Postnatal and Parenthood

Standard Statement
Transfer Standard: The transfer of women and their newborn babies into the community is planned to facilitate continuing effective care.

NHS Argyll & Clyde

Essential Criteria

5d.1: A system is established to ensure that information on women and their babies in the postnatal period is collated and transferred between secondary and primary care in a reliable, timely and secure manner.

STATUS: **Met**

Women within Argyll & Clyde carry their own maternity record which will include a copy of their discharge summary which is also copied to their health visitor and GP. These summaries are generally faxed to ensure speedy transfer of information and often followed-up by a telephone call to confirm receipt.

5d.2: Guidelines for transfer and post transfer care are in place.

STATUS: **Met**

Written guidelines for transfer of a woman and her newborn baby from the CLU to her home are held at all midwifery workstations within Royal Alexandra Hospital. On transfer, the woman also carries information about her postnatal period and the transfer. Post transfer care is arranged by the midwife in collaboration with the health visitor.

Appendix 1 – Glossary of abbreviations

Abbreviation	
AHP	allied health profession
ALSO	advanced life support in obstetrics
CLU	consultant-led maternity unit
CMU	community maternity unit
EPAS	early pregnancy assessment service
GP	general practitioner
GROS	General Register Office for Scotland
IR1	incident reporting form
MSLC	maternity services liaison committee
NCT	National Childbirth Trust
NHS QIS	NHS Quality Improvement Scotland
NICU	neonatal intensive care unit
NLS	newborn life support
RCA	Royal College of Anaesthetists
SANDS	Stillbirth and Neonatal Death Society
SBR	Scottish birth record
SCBU	special care baby unit
SEHD	Scottish Executive Health Department
SIGN	Scottish Intercollegiate Guidelines Network
SMR02	Scottish Morbidity Record 2
TENS	transcutaneous electrical nerve stimulation

UNICEF/WHO	United Nations Children's Fund/World Health Organisation

Appendix 2 – Details of review visit

The review visit to NHS Argyll & Clyde was conducted on 20 June 2006.

Review team members

Mrs Fiona Dagge-Bell (Team Leader)
Professional Practice Development Officer

Dr Sean Ainsworth
Consultant Neonatologist, NHS Fife

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Public Partner, Forth Valley

Dr Justine Nanson
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Ms Pauline Small
LSA Midwifery Officer, NHS Fife

Dr Rennie Urquhart
Consultant Obstetrician, NHS Fife

Mr David Marshall (Observer)
Pharmacy Professional Adviser, Care Commission

NHS Quality Improvement Scotland Staff

Dr Avril MacLennan
Project Officer

Mr Steven Wilson
Team Manager

During the visit, members of the review team met with local health service personnel including anaesthetists, health visitors, midwives, neonatologists, obstetricians, paediatricians, paramedics, AHPs and GPs.

Appendix 3 – Maternity services project group members

Chair

Dr Jane Magill
Director, Robert Clark Centre for Technological Education, University of Glasgow

Project group members

Ms Gill Allan
Sister Midwife, NHS Tayside

Mrs Frances Arnott
Health Visitor, NHS Forth Valley

Ms Irene Barkby
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Dr Ian Bashford
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Clinical Senior Lecturer & Programme Director, Scottish Programme for Clinical Effectiveness in Reproductive Health, NHS Grampian

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Ms Joanne Thorpe
Midwifery Team Leader, NHS Argyll & Clyde

Dr Tom L Turner
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Support from NHS QIS was provided by **Ms Jan Warner** (Director of Performance Assessment and Practice Development), **Mr Steven Wilson** (Team Manager), **Mrs Morag Kasmi** (Senior Project Officer), **Ms Sharon Keane** (Project Officer), **Dr Avril MacLennan** (Project Officer) and **Mrs Lorraine Inglis** (Project Administrator).

Appendix 4 – Timetable of review visits

Organisation reviewed	Visit date(s)
NHS Argyll & Clyde	20 June 2006
NHS Ayrshire & Arran	7 June 2006
NHS Borders	19 April 2006
NHS Dumfries & Galloway	29 March 2006
NHS Fife	10 May 2006
NHS Forth Valley	17 January 2006
NHS Grampian	27 April 2006
NHS Greater Glasgow	25 May 2006
NHS Highland	16 March 2006
NHS Lanarkshire	2 February 2006
NHS Lothian	1 March 2006
NHS Tayside	16 February 2006
NHS Orkney	22 November 2005
NHS Shetland	8 November 2005
NHS Western Isles	6 December 2005

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